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ABSTRACT

Existing data are summarized and original data provided on minority participation rates in alternative services among the elderly. Data from several federally-funded programs, including Medicare and Medicaid, are presented. A group of 32 counties in the US, representing a universe of counties in which minorities constitute a large proportion of the elderly population, are selected--four counties for each of the four minorities. Participation rates for minorities in health services, homemaker services, and daycare are reported for the 32 counties. Data analysis shows marked differences in minority access to services according to categorical funding programs. Medicare data in particular show that minorities are under-enrolled, and even those who are enrolled are less likely to use Medicare-reimbursed services than are whites. However, among those minorities who do use Medicare benefits, a higher proportion of minorities than whites use Part B for home health services. Similarly, the average per-person expenditure for home health benefits is more for minority than for white elderly. The data suggest unequal access for minorities and therefore a population of elderly who, when they finally get services, are sicker and require more services at greater cost. (Author)

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THE PARTICIPATION RATES OF OLDER MINORITY PERSONS IN COMMUNITY-BASED SERVICES IN LONG-TERM CARE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Under contract to HRA, Community Research Applications, Inc. (CRA) has completed a study of the participation of minority elderly in community-based services in long-term care. A major portion of this study has focused upon participation rates, and upon barriers to participation. The selected community-based services were: homemaker services, home health services, day-care, and meals programs. First, I will discuss the data from four major funding programs: Titles III, XVIII, XIX, and XX.

Generally speaking, these data were inadequate for study purposes, as is suggested by the following observations:

1. No specification -- other than "White" and "Other" -- is made in most data bases.

2. Race data are not cross tabulated by age.

3. In the case of Title XIX, a number of States (which collectively include over 50% of all recipients) had failed to submit data to the Federal government, or had submitted incomplete or otherwise inadequate data.

4. Even in the case of Title III, which does require elderly minority data, cross tabulations by service are not available.

5. The Federal government does not require Title XX reporting by race.

Dealing first with Medicare data, the most recent report dealing with home health services (1975) suggests that minorities -- in the aggregate -- are receiving a proportionate share of services. That is, while minority persons 65+ represent 9% of the older population, 10% of those receiving home health care were minority persons, 10.4% of all home health visits were to minority persons, and 11.3% of all home health reimbursements were on behalf of minority persons.

However, this positive view deteriorates upon inspection of more comprehensive Medicare (1974) data. That is:

- a larger proportion of minority than of White elderly do not have Medicare coverage (A and B)
- a significantly lower proportion of minority enrollees than of White enrollees actually use services.

Medicaid data provide little insight, due to the absence of cross tabulations by age. For example, the fact that 18% of the minority population are recipients, as contrasted with 3.5% of the White population, tells us little about the relative participation rates among the elderly.

As regards Title XX, the Federal government does not require data on race in its reporting forms. We surveyed 10 States and found that only one was able to provide data by age, race, and service. In this State, minority older persons represent 2.31% of the population age 60 and over and they represent 9.6% of older persons receiving homemaker services.

Data at the Federal level are available for Title III of the Older Americans Act. In 1977, 42% of all home services, which includes all services delivered in the home, were delivered to older minority persons. Our survey of 16 States suggests that minority older persons are receiving a larger percentage of services under Title III than their proportion in the State. For example, in Alabama, Blacks represent 26% of the State population and receive 34% of the homemaker services. In Hawaii, where minorities represent 72.2% of the older population, they receive 79% of the homemaker services and 91% of the daycare services. In South Dakota, 16% of home service recipients are Native American; Native Americans represent 2.1% of the older population in that State.

Our overall conclusion is that available service use data are so limited, both in terms of what is collected and tabulated, and in terms of reliability, that no estimates regarding minority participation can be made from existing data bases at this time.

If there are to be national data available on minority older person participation rates in community-based health and social services, Federal reporting requirements will have to be modified. At present, reporting requirements tend to be "race free" and do not allow accurate determinations of minority use of services. Many of the categorical programs were implemented at a time when the social climate was such as to discourage questions about race. Growing sophistication has led to the awareness that determination of, and data collection on, minority status of service users is the only way to monitor the extent to which such persons are receiving a "fair share" of services.

In order that the Federal government may have systematic data on the extent to which minority older persons are participating in alternative services, and in order that State Agencies on Aging may be able to access the data which is essential to their advocacy role, i.e., ensuring that minority older persons receive at least a proportionate share of services, we recommend the following changes in reporting procedures.

1. Demographic information collected and tablulated on each service user should be specific as to ethnic status. Designations of "White" and "Other" are not at all helpful in determining which minorities may be having problems in accessing services.

2. Demographic information collected on each service user should be specific as to age and should be collected and tabulated in such a manner as to permit tabulations of specific race by age.

3. Data on individual users should be collected in a manner which makes it possible to determine which services they are using. Service use data should be routinely cross tabulated with age and race data so that it is possible to determine precisely what services are being used by whom. It is important to monitor not only minority access to services in general, but also access to specific services, e.g., physician, community-based alternatives, long-term care institutions, etc.

4. All data on minority use of specific services should be available in terms of number of users, average expenditure per user, and average number of units of service.

Because of the meagerness of data availability at the Federal and State levels, we decided to seek minority participation rate data at the provider level. We selected a sample of 32 counties in the United States from a preliminary pool of high minority density counties. Eight counties were selected for each of the four minority groups, taking into account the proportion of minority group to non-minority group persons and population density.

In each of the 32 counties, every agency which provides daycare services, home health services, homemaker services, or meals was contacted and asked to provide participation rate data, as well as data on barriers and facilitators to service use. Data were obtained from 205 agencies; only 19 agencies (9.2%) refused to participate.

Two questions were addressed: (1) do agencies serve a proportionate share of the target minority population (i.e., the minority they were chosen to represent in the study) and (2) do agencies serve a proportionate share of all minorities in the county? Before addressing these questions, we want to make it very clear that a proportionate share means just that: the relation between the percentage of minority persons being served and the percentage of minority persons in the county. This does not in any way speak to any concept of <u>appropriate</u> share. Minority older persons live on lower incomes and are known to suffer from worse health; therefore, it is likely

that they should receive more than a proportionate share of community-based long-term care services. However, this study was not designed to address that issue.

In addressing the first question, agencies were divided into three groups: those which serve a greater proportion of the target minority than the proportion of that minority in the county; those which serve an equal proportion (within 5 percentage points); and those which serve less than the proportion of that minority in the county.

Eighty-three percent of the agencies in counties chosen for their Black population serve an equal or greater proportion of Blacks than the county proportion of Blacks (64% of the agencies serve a greater proportion). Sixty-two percent of the agencies in counties chosen for their Hispanic population serve and equal or greater proportion of Hispanics than the county population (42% of the agencies serve a greater proportion). Sixteen percent of the agencies in counties chosen for their Oriental population serve a greater proportion of Orientals; the rest generally serve no Orientals at all. Ninety percent of the agencies in counties chosen for their Native American population serve an equal or greater proportion of Native Americans than the county proportion (39% of the agencies serve a greater proportion).

As an overall picture, most agencies appear to be serving at least a proportionate number of minority older persons.

However, where the particular minority represents less than 10% of the county population, and where the population density is such that there are relatively few persons of that minority group, the service needs of that minority are likely to go unmet. This has a differential impact on the different minority groups: there are many counties in which a large proportion of Blacks reside (our sample included the range 34%-64%). The range among Hispanics is far greater (7%-79%); among Orientals from .2% to 9%, and among Native Americans from 5% to 88%. Taking into account the fact that these counties represent the uppermost decile of county population proportions for each minority, it follows that whereas Blacks comprise a substantial proportion of the residents in many counties, Orientals command no such position in any county.

In response to the second question, i.e., do agencies serve a proportionate share of all minorities combined in the sample counties, fifty percent of the agencies in the sample are serving a greater proportion of all minority persons than the proportion of all minorities in the county population; another 20% of the agencies are serving a proportion of minority persons which is equal (within 5 percentage points) to that of the county; 10% of the agencies could not provide adequate data for this analysis; 20% of the agencies are serving a disproportionately-low minority client group.

In conclusion, based on the data from the 205 agencies in the 32-county sample, the following points can be made about the participation rates of older minority persons:

1. The majority of agencies (70%) serve a proportion of minority older persons which is commensurate with the proportion of minority persons in the county in which the agencies are located.

2. The likelihood that minorities will receive at least a representative share of services increases as their density in the population increases. Problems in obtaining a representative share seem to arise in low density population counties where minorities represent less than 10% of the population. In many such cases, service providers appear unaware of the fact that the minority even exists to any significant extent within their county. In low proportion minority counties which have a high minority density, however, there do appear to be service providers who almost exclusively serve that minority.

As the title of this paper suggests, the paper is designed to provide information about participation rates. However, I cannot resist giving you some flavor of the findings regarding barriers/facilitators to older minority person service use.

In contrast with agencies which are underserving older minority persons, agencies serving a relatively high proportion of minority group members are significantly different along the following dimensions:

1. The agency is likely to have an outreach component and make its services known to potential minority clients and to other agencies.

2. The minority to total staff ratio is higher than the minority proportion in the county.

3. The staff has had training on the special needs and cultural values of minority persons.

4. The administrator believes that staff training on minority needs is important.

5. The administrator believes that minority representation on staff is important.

6. The administrator believes that minority representation on the Board is important.

7. The minority to total Board ratio is higher than the proportion of minorities in the county.

8. The administrator believes that location of the program, or of a satellite center, in a minority neighborhood is important.

9. The agency is more likely to be located, or to have a satellite located, in a minority neighborhood.

10. The agency is likely to be a public agency rather than a private agency.

Multiple regression analysis showed that the single most important variable which contributes positively to the percentage of minority clients served is the percentage of minority staff in the agency. The second most important variable is location of the program office or of a satellite center in a minority neighborhood. The only other positively-associated variable with the percentage of minority older persons served by an agency is the percentage of minorities in the county. There is a strong negative association between proprietary sponsorship and a high percentage of minority clients. Proprietary agencies which receive no Medicare or Medicaid reimbursement serve only private pay clients; minority older persons simply cannot afford to pay for these services. Although the relationship is much less strong, non-profit agency sponsorship is also negatively related to the proportion of minorities served.

In summary, two points emerge:

1. That data collection, aggregation and presentation procedures need to be upgraded and standardized.

2. That relative utilization of community-based services by minority elderly depends on a variety of situational and demographic variables which should be input into the planning process.